South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Work Phone: ( ) - _____ Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) - _____

DIRECTIONS: Please print or type. Answer the following questions about your claim to the best of your ability. If you cannot answer a question, leave it blank. Use additional sheets of paper, if necessary. Please use short statements.

Questions

Did the Commissioner fail to consider important reasons for award of compensation? If so, what reasons? _____

Did the Commissioner incorrectly decide the facts? If so, what facts? _____

Do you think the Commissioner applied the wrong law? If so, what law? _____

Do you feel there are any other reasons why the Commissioner's judgment was wrong? If so, what? _____

What action do you want the Commission to take in this case? _____

_____ _____
Signature Date

IMPORTANT: A copy of this Brief and any attachments must be filed with the Commission within 10 days of receipt of the Review Hearing Notice, Form 31. The Commission will serve your Brief on the employer's representative. Questions about the use of this form may be directed to the Commission's Judicial Department.